3. A PPS-exempt hospital (TEFRA) such as rehabilitation hospitals, children's hospitals, or free-standing psychiatric hospitals, qualify if it is reimbursed by or eligible to be reimbursed by TEFRA (Tax Equity and Finance Reduction Act) methodology as described in Section II of this policy.

4. The reserve pool is to compensate DSH qualifying hospitals which have had a disproportionate shift in the delivery of services between low-income and Medicaid-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in paragraph A.2.b.ii, exceeds 20 percent. A qualifying hospital may receive a payment from the reserve pool in addition to its payment from one of the three other pools.

C. Disproportionate Share Hospital Payments

The DSH funds allocated to each pool are paid to qualifying hospitals based on the number of Medicaid discharges. These include both Medicaid managed care and non-managed care discharges. A discharge occurs when a patient dies in the hospital, is formally released from the hospital, or is transferred to a another hospital or nursing home.

Payments are made quarterly, with the annual amount for the pool divided into four parts, and each part distributed after the end of each quarter based on Medicaid discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools 1, 2, or 3 will be computed by dividing the number of Medicaid discharges for that hospital by the total number of Medicaid discharges from all hospitals qualifying for that DSH pool and then multiplying this pro rata share by the quarterly allocation for the respective pool. This amount cannot exceed the OBRA 93 DSH limit, which is described in sections IV.E. and IV.F.

The Medical Assistance Division will review the allocation of DSH funds prior to the start of each State Fiscal Year and may re-allocate funds between pools at that time in consideration of shifts in the hospital utilization of Medicaid and low-income/indigent care patients.

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The amounts allocated to each pool for state fiscal year 98 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the Medicare Prospective Payment Update Factor (MPPUF) and/or the DSH budget as defined by HSD. The base year DSH budget for state fiscal year 98 is $22,000,000.00.

1) The Teaching PPS hospital DSH pool is 56% of the overall DSH budget, as defined by HSD.

2) The Non-teaching PPS (DRG) hospital DSH pool is 22.5% of the overall DSH budget, as defined by HSD.

3) The PPS-exempt hospital (TEFRA) DSH pool is 1.5% of the overall DSH budget, as defined by HSD.

4) The reserve DSH pool is 20% of the overall DSH budget, as defined by HSD. Quarterly payments may be made directly from the reserve pool to hospitals qualifying for any of the other three DSH pools at the rate of *N* dollars per Medicaid discharge, where *N* is equal to the fraction described in paragraph A.2.b.ii of this section minus 20% multiplied by $1750.

D. Request for DSH Payment Procedures

Hospitals must submit to the Department the number of Medicaid discharges (both managed care and fee for service discharges), which they have incurred 30 days after the end of each quarter. The Department will review the hospital's documentation supporting their discharge information. Any requests received later than 60 days from the end of the quarter will be denied as untimely.

E. DSH Limits

Pursuant to section 1923(g) of the Social Security Act, a limit is placed on the payment adjustment for any hospital. A hospital's payment adjustment determined under sections IV.B. through IV.D. shall not exceed that hospital's hospital-specific DSH limit, as determined under section IV.E. This limit is calculated as follows:

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DSH Limit=M+U

M= Cost of services to Medicaid patients, less the amount paid by the Medicaid program under the non-DSH payment provisions of this plan.

U= Cost of services to uninsured patients, less any cash payments made by them.

The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The "costs of services" is defined as those costs determined allowable under this plan.

"Uninsured patients" are defined as those patients who do not possess health insurance or do not have a source of third party payment for services provided, including individuals who do not possess health insurance which would apply to the service for which the individual sought treatment. Payments made to a hospital for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered to be a source of third party payment.

F. Limitations In New Mexico DSH Allotment

If the DSH payment amounts as described in section IV.C. through IV.E. above, exceed in any given year, the federal determined DSH allotment for New Mexico, the DSH allocations by pool will be reduced proportionately to a level in compliance with the New Mexico DSH allotment.

V. DETERMINATION OF ACTUAL, ALLOWABLE, AND REASONABLE COSTS

A. Adequate Cost Data

1. All hospitals must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The hospital will submit a cost report each year.

The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

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2. The cost finding method to be used by hospitals will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers/

   All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later.

   Generally when two centers render services to an equal number, that center which has the greatest amount of expense will be allocated first.

B. Reporting Year

For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

C. Cost Reporting

At the end of each of its fiscal years, the hospital will provide to the department or its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico Title XIX cost reporting form. The cost report must be submitted within 90 days after the close of the hospital's fiscal year. Failure to file a report within the 90 day limit, unless an extension is granted, will result in suspension of Title XIX payments, until such time as the report is received.

D. Retention of Records

1. Each hospital will maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the New Mexico Title XIX cost report to the Department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records available upon demand to representatives of the Department, the State of New Mexico Audit Agent, or the United States Department of Health and Human Services.

2. The Department or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such reports.

E. Audits

1. Desk Audit: Each cost report submitted will be subjected to a comprehensive desk audit by the State's audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the Department.

2. Field Audit: Field audits will be performed on all facilities as per the auditing schedule established by Medicare. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report are accurate, complete, and reasonable. The field audits are conducted in accordance with generally accepted auditing standards. Field audits are of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost was accurately determined and reasonable.

   After each field audit is performed, the audit agent will submit a complete report of the audit to the Department. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate, and reasonable. These audit reports will be retained by the Department for a period of not less than three years from the date of final settlement of such reports. Audits will be performed in accordance with applicable Federal regulations.

F. Overpayments

All overpayments found in audits will be accounted for on the HCFA-64 report in accordance with 42 CFR 433.300 through 42 CFR 433.322.

G. Allowable and Non-Allowable Costs

Allowable costs, non-allowable costs, and reasonableness of costs will be determined as on the basis of the HIM-15.

VI. PUBLIC DISCLOSURE OF COST REPORTS

A. As required by law, cost reports submitted by participating providers as a basis for reimbursement are available to the public upon receipt of a written request to the Medical Assistance program audit agent. Disclosure information is limited to cost report documents required by Social Security Administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the Medical Assistance Program audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 days in which to comment to the requestor before the cost report is released.

D. The cost for copying will be charged to the requestor.

VII. SEVERABILITY

If any provision of this regulations is held to be invalid, the remainder of the regulations shall not be affected thereby.